Investor Relations

# Q1 2026 results

## Conference call and webcast for investors and analysts
## Wednesday, 29 April 2026 at 12:00 BST

### Introduction | Constantin Fest

#### Slide 1
Conference call and webcast for investors and analysts

#### Slide 2 | Agenda
Ladies and gentlemen, a warm welcome to the GSK Q1 2026 results call.

I am delighted to be joined today by Luke Miels, Nina Mojas, Deborah Waterhouse, Tony Wood and Julie Brown. And in our Q&A session we will be joined by David Redfern.

Today's call will last approximately one hour with the presentation taking around 30 minutes and the remaining time for your questions.

Please ask only 1-2 questions so that everyone has a chance to participate.

Before we start, please turn to slide 3.

#### Slide 3 | Cautionary statement regarding forward-looking statements
This is the usual safe-harbour statement.

We will comment on our performance using constant exchange rates or CER unless otherwise stated.

I will now hand over to Luke.

## Q1 2026 performance: strong sales growth and earnings delivery | Luke Miels

### Slide 4 | Q1 2026 performance: strong sales growth and earnings delivery

Thank you and welcome everyone.

Q1 performance was strong.

- Sales were up 5% to more than £7.6bn.
- Growth was driven by Specialty Medicines which were up 14%, with Vaccines also contributing particularly through strong Shingrix sales
- Core operating profit grew 10% and EPS was up 9%
- Cash generation was strong at £1.4bn
- And our Q1 dividend declared today is 17p pence

Looking forward, we expect another year of profitable growth - reflected in the guidance confirmed today.

Next slide please.

### Slide 5 | Key focus areas to drive value

In February, we set out our priorities to drive value. We've made a good start but we've got more to do.

In a minute, Nina will share progress on how we're delivering growth including the launches of Nucala COPD, Exdensur and Blenrep.

We're also assessing our pipeline on an ongoing basis, the aim being to progress high potential assets more aggressively.

- As we identify differentiated profiles that fit an unmet need or address a gap in the market – we will then and are using scientific courage to make decisions in an accelerated way. This includes internal development as well as BD.
- Now, we're already making progress here with our assets in COPD, with our ADCs in oncology, and with efimosfermin in MASH.

Now, we'll talk more about these and other high value opportunities at Q2 results. And this will include an update on our HIV pipeline instead of an HIV only event in June.

Continuing to underpin this, are our efforts to simplify how we work - with greater pace, accountability and focus. I'll now hand over to Nina.

## Growth drivers | Nina Mojas

### Slide 6 | Growth drivers

Thanks, Luke.  Please turn to the next slide.

### Slide 7 | Q1 growth driven by Specialty Medicines and *Shingrix*

Commercial momentum continued in Q1 driven by *Shingrix* and strong growth for key products across our Specialty portfolio, which grew 14%.

General Medicines was down 6% in the quarter, driven by declining sales of the older established portfolio. *Trelegy* performance did not offset the broader portfolio decline as its growth in the US was limited by increasing co-pay requirements due to Medicare redesign. These are especially pronounced in the first quarter and are expected to be less relevant in the rest of the year.

As Luke mentioned, we are focused on the products that drive the most value – including new launches and growth contributors.

Next slide please.

### Slide 8 | Key products driving growth

*Shingrix* was a key driver in Q1 – setting a record for quarterly sales, delivering more than £1bn, up 20%.

Quarterly patterns continued with strong sales in Q1 driven by:

- Europe, where sales were up 51%, following uptake in national immunisation programmes and private market demand.
- And the US, where sales grew 12%, driven by inventory movements, including the launch of the new pre-filled syringe
- Moving forward this year, we expect tougher comparators for Europe and Japan as most large immunisation programmes annualise.
- Further penetration opportunities remain with around 11% of the eligible population immunised in our top 10 markets, outside the US.

In Oncology, *Jemperli* was again a key growth contributor delivering £232m, up 40%, driven by its significant overall survival benefit in endometrial cancer

- At the Society of Gynecologic Oncology, we presented data from a four year follow up of the RUBY study, which showed an overall survival benefit over time; with 66% reduction in risk of death for patients with dMMR/MSI-High endometrial cancer.

- We look forward to the continued development of this medicine - including in rectal cancer – with pivotal results from AZUR-1 in the second half of the year.

Next slide, please.

## Slide 9 | Strong *Nucala* COPD launch and early signals for *Exdensur*

*Nucala* also delivered double digit growth in Q1 following its expansion into COPD in the US last year.

- US growth was driven by a broad COPD label and the halo effect on other indications.
- Total brand-new patient starts are now at their highest level, growing 65% year-on-year and we are accelerating momentum toward market leadership in COPD with around 45% of market share.
- COPD launches outside of the US including Europe and China have similar strong initial signals. For example, in China we are already capturing around 1 in 2 new patients representing a strong early launch in one of the largest markets globally, with around 100 million people living with COPD.

In the severe asthma space, our focus is now on *Exdensur*, for which access in the US is still limited ahead of obtaining the J-code. Severe asthma is an area where significant opportunity remains as only 30% of eligible patients are receiving a biologic.

- The ultra-long-acting dosing of *Exdensur* is a key value driver with around 97% of patients preferring 6 monthly dosing vs current options
- This is also valued by prescribers as they understand that longer dosing intervals lead to greater adherence and therefore better outcomes. Currently, 65% of patients discontinue their short acting biologic in the first 12 months
- The next critical milestone in the US is obtaining the J-code – which is expected early July after which we expect access to be unrestricted.

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## Slide 10 | *Blenrep:* early launch success with strong indicators for future growth

Moving to *Blenrep*, our community-ready ADC for multiple myeloma

- Simple administration and overall safety remains a differentiating factor as 70% of patients are in the community and accessibility to competitor options remains a challenge
- In the US, we now have a majority of use in the community – an important indicator of success as academic centres tend to be the early adopters
- Our data, showing an extended benefit vs standard of care, is resonating, as is the simplicity of our REMS and coordination of eye care professionals. The number of US HCPs prescribing is growing with many repeating.

- Outside of the US we have 2L approval in 19 markets, most recently in China and we are progressing with launches in all major markets including the UK, Germany and Japan.

And with that, I will hand over to Deborah

## HIV Performance | Deborah Waterhouse

### Slide 11 | Long-acting portfolio powers HIV growth and market share | Deborah Waterhouse

Thank you Nina. I'm delighted to share another strong quarter of double-digit HIV sales growth of +10% driven by our long-acting portfolio and *Dovato*.

Demand and market share increased across all regions, most notably in the US where sales grew +15% with treatment market share outpacing the competition. In Europe, we continue to capitalise on our long-standing market share leadership position.

Competitive execution is powering our portfolio transition to INSTI-led long-acting regimens, which consistently represent >70% of our total HIV growth, and more than 1/3 of total US sales.

With treatment accounting for around 90% of the total HIV market – we're delighted that *Cabenuva* grew 31% in Q1 fueled by patient demand. We also saw accelerated switches from competitor products, reaching 79% in the US this quarter.

*Apretude* grew strongly at 44% in the quarter, withstanding impact from a competitor launch and reinforcing the importance, of our more than 99% effective, highly tolerable, single-shot long-acting injectable for HIV prevention.
We are outpacing the field with our patient-centred pipeline built on a foundation of long-acting integrase inhibitors, the gold standard of HIV care.
For 3x yearly *Cabenuva* for treatment, our CUATRO Ph3 registrational study start is on track and we expect to launch in 2028. Building on the success of 6x yearly *Cabenuva* - the first and only complete long-acting injectable for HIV treatment – we believe this potential option will establish a new standard of care highly desired by patients and doctors, while doubling provider administration capacity.

Our 3x yearly *Apretude* for PrEP is set to redefine HIV prevention once again, with registrational study data anticipated in H2 2026 and a H1 2027 launch. We strongly believe this asset - delivered through one injection, with dosing frequency linked to routine sexually transmitted infection testing cycles - has the optimal PrEP profile, better aligned to patient and HCP preference.

At CROI we shared data underscoring the strength of our pipeline assets which we are evaluating for our twice yearly long-acting injectable treatment and we remain on track to launch by the end of the decade.

- Data for VH184 - our first third-generation INSTI, with IP protection through to 2040, demonstrated potential for twice-yearly dosing, and an enhanced in-vitro resistance profile vs BIC.
- Our capsid inhibitor - VH499 – also showed promising potential for twice-yearly dosing. This differentiated asset is highly potent and has a low risk of DDIs
- And, data for our bNAb lotivibart, showed high efficacy for 3x yearly dosing when combined with monthly cabotegravir. We look forward to sharing twice-yearly data later in 2026

As we advance our pipeline at pace, continue to deliver strong portfolio performance and prepare for our two upcoming 3x yearly launches, we are well positioned to manage the dolutegravir loss of exclusivity and drive sustained, long-term growth.

And as Luke said earlier, we will share more about the HIV pipeline at Q2 results.

I'll now hand over to Tony.

## Pipeline progress | Tony Wood

### Slide 12

Thank you, Deborah. Next slide please.

### Slide 13 | Further pipeline acceleration and progress across late-stage assets

In R&D our top priority is to accelerate development to deliver new products to patients faster and, as you heard from Luke, we have been taking specific actions to advance our most exciting opportunities.

In 2025, we started 7 phase III trials with 10 more starting this year. We are making bold investment choices to drive value in the late-stage pipeline.

For example, our pivotal 2L trial in Small Cell Lung Cancer EMBOLD 301, for ris-rez, our B7-H3 ADC, is recruiting well. We anticipate the expansion of the ris rez programme with a number of phase III trials planned, including in genitourinary cancers which start later this year.

Similarly, for mo-rez, our B7-H4 ADC, we have recruited more than 200 patients into BEHOLD-1 and presented phase I data for Ovarian and Endometrial Cancers at SGO earlier this month. We have now initiated two phase III studies, with three more scheduled to start recruiting before the end of the year. More on mo-rez in a moment.

StrateGIST 3, the first phase III trial for velzatinib in 2L GIST, started recruiting at the end of last year, less than 12 months after acquiring the asset. A second phase III trial in a 1L patient population will start in the second half.

Elsewhere in Oncology, at ASCO this year, we have five oral abstracts accepted for presentation including data from the DREAMM-9 study which will inform dosing strategy for newly diagnosed multiple myeloma patients. This schedule will be employed in DREAMM-10 and in PrECOG, an upcoming co-operative group study.

In RI&I we acquired efimosfermin in May 2025, where our priority was to advance this asset into phase III. Our two pivotal studies started last year, ZENITH 1 and 2 in F2-F3 stage MASH, and are recruiting well, with the NEBULA programme for advanced MASH on track to start later this year.

Moving to pivotal readouts. We reported positive headline results for bepi during the quarter, which I will cover shortly, and we have 4 further phase III readouts to come in the second half for Jemperli in rectal cancer, camlipixant in refractory chronic cough, *Exdensur* in EGPA and our 3 times yearly pre-exposure prophylaxis for HIV.

Lastly, our Business Development activities continue to complement and enhance our portfolio. In Q1 we announced two acquisitions, ozureprubart in food allergies and HS235 in pulmonary hypertension. Both have clinically validated MOAs and the potential to be BIC. These assets build on GSK's existing expertise in respiratory and inflammation.

Next slide please.

## Slide 14 | Bepirovirsen: functional cure for patients with chronic hepatitis B

As I briefly mentioned, we have announced positive phase III data for our functional cure for Chronic hepatitis B, bepirovirsen. The B-Well 1 and 2 data show a statistically significant and clinically meaningful increase in the rate of functional cure and the full data will be presented at EASL in May.

This outcome is important for patients because Chronic Hep B infection is associated with high rates of liver cancer and an increase in all cause mortality. A recent US epidemiology study in Hepatitis B patients

showed that loss of surface antigen was associated with an 89% reduced risk of hepatocellular carcinoma and a 62% reduced risk in all cause mortality.

Regulatory reviews for bepi are progressing well. Bepi now has breakthrough designation in the US and a PDUFA date of the 26 October and has been accepted for Priority Review in China. Commercial preparations are underway in these two markets, which represent around two thirds of the commercial opportunity globally.

Next slide please.

## Slide 15 | Mo-rez (B7-H4) – acceleration into 5 pivotal studies in OC and EC

Turning to pipeline progress in oncology, and our global BEHOLD-1 phase I study of mo-rez in advanced endometrial cancer and platinum-resistant ovarian cancer.

Mo-rez is a B7-H4–targeting ADC and B7-H4 is overexpressed in many gynaecologic tumours with low expression in normal tissues.

In this dose-escalation study, mo-rez showed encouraging anti-tumour activity. At the highest doses, confirmed ORR was 62% in PROC and 67% in advanced EC, with responses observed regardless of B7-H4 expression.

Durability of response data were also encouraging. In the highest-dose PROC cohort, only 1 patient from 21 progressed within six months.

Mo-rez was generally well tolerated, with low discontinuation rates and incidence of ILD - only about 3% of patients reported mild/moderate pneumonitis.

Based on these exciting data, and additional data from our partner Hansoh, we plan to start five pivotal trials this year in EC and OC.

Next slide please.

## Slide 16 | Ris-rez (B7-H3) - promising phase I data in NSCLC

Elsewhere in our oncology portfolio, our partner Hansoh presented new ris-rez data at a plenary session at AACR earlier this month.

The data are from a Hansoh sponsored Phase I study called ARTEMIS-101, which looked at ris-rez in combination with a PD-L1 in 40 patients with 2L+ non-squamous non-small cell lung cancer.

The data show a 47% ORR, with a median PFS of 14 months. The combination was generally well tolerated, with Grade 3 adverse events mostly reflecting haematological toxicity consistent with similar ADCs. 4 cases of treatment related ILD were reported in the study – and these are grade 1 or 2.

These exciting data were used to support the start of a phase III non-small cell lung cancer trial in China, and we plan to initiate a phase II study for ris-rez in combination with Jemperli in a global population.

Next slide please.

### Slide 17 | Acquisition of 35Pharma and HS235, a potentially BIC activin signalling inhibitor in pulmonary hypertension

As I mentioned, accessing innovation through BD continues to be key to acceleration and growth.

In February we announced an agreement to acquire 35Pharma. Their lead asset is HS235, a potential BIC, clinically validated, activin-signalling inhibitor to treat Group 1 and Group 2 pulmonary hypertension. HS235 is currently in phase I development.

PH is a progressive and life-limiting disease, with high symptom burden and sub-optimal patient outcomes. 5 year survival rates are around 50%. This is an under served area in cardiopulmonary medicine, with few available disease modifying treatment options and significant growth potential. HS235 has the potential to treat patients while reducing bleeding related side effects and providing metabolic benefits versus existing therapies. Entering cardiopulmonology disease complements GSK's commercial footprint, providing new opportunities to achieve broader coverage across the multiple chronic diseases which affect the lung, liver and kidney.

We successfully closed the transaction on the 15 April and look forward to moving this asset into phase II development at pace.

I'll now hand over to Julie.

## Q1 2026 financial performance | Julie Brown

### Slide 18

Thank you Tony and good afternoon everyone.

Next slide, please.

## Slide 19 | P&L leverage and accelerated pipeline investment

Starting with the income statement for the quarter:

- Sales grew 5% and gross margin improved 110bps due to the growth of Specialty and Shingrix benefiting product mix this quarter.
- SG&A declined 2% helped by positive IP settlements. On an underlying basis SG&A grew 2%, demonstrating P&L leverage and continued productivity improvements.
- R&D spend was driven by accelerated investment in the pipeline, including the efimosfermin and velzatinib pivotal trials. We will continue to invest in R&D as we initiate multiple late-stage trials across our Specialty portfolio.
- Royalties benefitted from Abrysvo and Comirnaty income streams.

And operating profit grew 10% in the quarter including the legal settlements, which were worth +3pp.

EPS grew 9%, impacted by a higher tax rate and increased finance expenses, partially offset by the benefits of the share buyback.

Next slide, please.

## Slide 20 | Cash generation supporting investment in growth

Turning to the cash flow and capital allocation, cash generation was strong, albeit partially masked by the impact of adverse currency:

- CGFO was slightly ahead of last year, with increased operating profit and IP income from the CureVac settlement broadly offset by the timing of trade payables
- Free cash flow benefitted from the $250m special dividend received as part of the changes to the ViiV shareholding structure.

Looking ahead, we remain on track to reach our target of >£10bn CGFO, with cash flows weighted, as normal, towards H2.

Next slide, please.

## Slide 21 | Capital deployment prioritises business growth and shareholder returns

Strong cash generation and strategic actions have supported our capital allocation priorities with Net Debt at 1.4x EBITDA:

- Investment in BD primarily comprised the £1.4bn upfront to acquire RAPT Therapeutics
- SH returns totalled over £0.9bn and the SBB is on track to be completed at the half year

- In the second quarter we expect to have an outflow of $950m for the acquisition of 35Pharma

And we are optimising the portfolio and generating cash income to reinvest in the business; including the ViiV special dividend, the divestment of the Rockville manufacturing site and the out-licensing of linerixibat. These transactions will positively impact net debt by $1.2bn in the first half, including linerixibat, completed in Q2, yielding $400m.

Next slide, please.

### Slide 22 | 2026 guidance confirmed

Looking to the full year, we are confirming the guidance shared in February.

In terms of phasing, we remain on track for our FY product group guidance with a few things to note;

- First, Vaccines growth in Q1 benefitted from the US Shingrix prefilled syringe stocking, and from Q2 onwards we will begin to annualise the publicly funded programmes in Japan and certain EU countries last year
- Second, Gen Med growth is expected to be H2 weighted. Notably, in the second quarter, Trelegy has a tough comparator due to prior year true up benefits and International markets are expected to remain challenging.

We still expect operating profit growth to be predominantly H2 weighted, given the phasing of productivity benefits and you'll recall we will also be comping the RSV IP settlement received in Q2 last year.

Next slide, please.

### Slide 23 | IR Roadmap 2026 to 2027

Turning to our roadmap, which shows our commitment to deliver.  We've made a strong start to the year in terms of execution, pipeline and disciplined capital allocation, including the acquisition of two new high potential assets.

And with that I am happy to hand back to Luke.

## Summary | Luke Miels

### Slide 24 | Summary: Creating value for patients and shareholders

Thanks Julie.

In summary - we have made a good start to 2026.

We are completely focused on managing the business to drive topline growth and accelerate the pipeline.

And we are committed to taking the critical steps needed to do this.

We look forward to updating you more at our Q2 results in July.

Thank you, and we will now move to Q&A.

- Question & Answer Session -

Constantin Fest: Thank you, Luke. I'd like to remind everybody to limit yourselves to ask one question, please. This will allow more time for everyone to ask questions. First question comes from Kerry Holford. Kerry, please go ahead.

**Kerry Holford (Berenberg):** Hi, there. Thank you for taking my question. Nina, here's one for you on Exdensur. On the slide you showed, you talked of around 65% of patients discontinuing short-acting biologics in respiratory within the first 12 months. So that seems higher than I might have thought.

So I'm just interested to see if you've got more detail on why those patients are discontinuing. Does it relate to efficacy, safety, perhaps compliance difficulties relating to the monthly dosing? And then also, what happens to those patients who discontinue? Do you see them return? Thank you.

Nina Mojas: Yeah. Sure. So, Kerry, there are a number of reasons, but one of them, and a significant one, is compliance and the requirement for frequent dosing, which, as you know, varies from every two weeks to every four weeks for short-acting.

What happens to those patients? They will usually go back to inhaled medicines, and some of them eventually will might come back again to a biologic. I'm not sure what that proportion would be, but we usually characterise patients, who have not been on a biologic for 12 months as new to biologic. But in a nutshell, a number of reasons, compliance being a significant part of that.

**Zain Ebrahim (JP Morgan)**: Thanks a lot for taking the question. My question is on the strategy update that you're expected to provide with the Q2 results. What could we expect to learn from you there in terms of your pipeline? How much emphasis should we expect from you on the midterm outlook to 2031 versus

the longer term outlook beyond 2031? And you've made comments at Q1 about, or Q4 even, about the HIV business, and we've seen the six monthly data since then. So could we still expect you to provide an outlook on how HIV might look in 2031?

Luke Miels: Sure. Thanks. I mean, we've obviously been very busy. There's been a very aggressive prosecution of opportunities to accelerate the late-stage pipeline. I direct you to the bottom right-hand corner on Slide 13 in Tony's presentation. I think it's a good summary of it.

And so, yes, I think the timing made sense at that point to take more time to lay out the whole portfolio, both in terms of things that we can do that have midterm impact as well as longer-term impact, and HIV will be embedded within that, because, again, we want people to look at the total business and aggregate and the progress that we're making there. So, yes, I think that's a good summary at this point. Thanks, Zain.

**Graham Perry (Citi)** Great. Thank you. It's a question on bepirovirsen. The PDUFA is coming in October. We've got data coming at EASL. Perhaps you could just outline the opportunity you see for the molecule. Do you see it more as a high-priced U.S. centric asset or a lower-priced, higher-volume asset across China? And can you achieve differential pricing across the regions?

And on label expectation, you're expecting a label for the broad population or just the low hepatitis B surface antigen group. I think it's less than 1,000 international units per mil population that you flagged in the headline press release has better functional cure rates. Thank you.

Luke Miels: Sure. No worries. Nina, do you want to, or maybe Tony, if you go into the data EASL reg pathway, and then we can get into the IP.

Tony Wood: Yes. So, Graham, I'm not going to get into the details of the label, but just to remind you that the B-Well 1 and B-Well 2 studies were chosen from the population that had a surface antigen level of 3,000 or less. So I think it's important to understand that the complete B-Well population will cover that broader group.

That's about 65% of the ITT population. The 1,000 group is about 45%. And as I've said in the past, the data we have suggests that there is a relationship between surface antigen level and outcome, but you shouldn't interpret that as being a linear one.

Luke Miels: Yeah. And I mean, the other thing I'd add before, Nina, if you wanted to add anything else, if you look at the thousand cut-offs surface antigens, about 45% of the population, U.S. patients, the bulk of them are vertically infected. It's around 1.2 million of whom about just over 300,000 are on treatment today.

Europe's a little more in terms of 1.4 million. And yeah, about 200,000 on treatment. China's much larger in terms of 57 million sort of infected, but only 16 million are diagnosed and they have much greater usage of pegylated interferon there. So, yeah, I mean, the treated population is around 10 million.

But what we're being thoughtful about is particularly the strategy in China. I think the strategy in the U.S. and Europe is very clear. What we're reflecting on very actively is the pathway to launch in China.

Nina, anything you want to add on that?

Nina Mojas: Yeah. Maybe I would just say, the way we think about is the way we see the opportunity, about 70% of the opportunity are between U.S. and China. As Luke mentioned, U.S. in hundreds of thousands in treated patients diagnosed are probably only about one-third of the total.

And the way we see the opportunity now reflects really those patients who are currently treated. Those are patients who have high desire to be treated. And again, still in the U.S., U.S. market is highly focused on relatively limited areas. So there are about five states in the U.S., where hep B is prevalent and treated. And these are unsurprisingly states that have relatively high number of immigrants from Asian and African countries.

And those who are treated clearly have access to treatment. So, this is unlike hep C. This is patient population that have insurance, that have means to be treated and then have desire to be treated. So that gives you a little bit of sense about where we are going and how we are going to approach that. It's quite focused area geographically.

In China, about 70% of patients or a patient of potential market potentially is in about top 15% of the accounts. So again, fairly focused approach in a country, where hepatitis B is considered to some extent to be a stigma with very high desire of treatment. That's why you have very high use of interferon, which is not a pleasant drug to be on for a very long time.

Tony Wood: And just one more, Graham, one final point to finish off. Remember, we said before that 15% to 20% functional cure across the population would be considered clinically meaningful, and that's reflected in the expedited designations that we're getting, including the most recent one, obviously, from the FDA.

Luke Miels: Thanks, Graham. Hopefully, we'll see you at EASL. Next question, please.

**Rajan Sharma (Goldman Sachs):** Thanks for taking my question. Just one on HIV, and obviously, we're expecting some competitor data for a once-weekly oral treatment option this year. Some of the physician feedback that we've had suggests that there'll be strong demand for that. So, Deborah, just wanting to understand how you think about that from a ViiV perspective in terms of near-term impact, and then ultimately, do you think that that is restrictive to ultra-long-acting injectable? Thanks.

Deborah Waterhouse: Yes, thanks, Rajan. So, in terms of the once-weekly oral that's being launched for next year and dated this year, I think, is islatravir plus lenacapavir.

So, I think what we have communicated is critical to successful regimens that are robust in HIV is having an integrase inhibitor at the core. Today, about 85% of people globally are on an integrase inhibitor-based regimen. And certainly, where we've got two drug regimens, such as Dovato, having an integrase at the core, I think is pretty critical.

So, I think it will be interesting to see the data, but I think, for me, when you get to really outstanding weekly orals, it will be with an integrase at the core. And then, of course, there are, let's see where we are with islatravir. Obviously, we've seen challenges with islatravir at higher doses in terms of depletion of CD4 counts.

And I think physicians have questions about longer-term, will that manifest itself even at a lower dose if somebody's on this medicine for a long time? However, undoubtedly, there will be some uptake. And all the research that we've done says that the weekly orals cannibalizes the daily orals. Actually, our research shows that it doesn't impact long-acting injectables, because that is a very specific patient segment where

you've got people who struggle to adhere, who really feel very stigmatized by taking a tablet every day, or are really worried about people discovering their status, as well as, obviously, the benefit of, directly observed therapy. So, I think the long-acting injectable segment won't be impacted by the once-weekly, but the daily orals are most likely to.

**Sachin Jain (Bank of America):** Two quick questions for you. One on camli. I'm sure you're expecting this, but level of excitement headed into CALM-2 with CALM-1 in-house, I guess? And then secondly on HIV, one of your key narratives obviously, Luke and R&D team is acceleration of key assets. Given the importance of long-acting injectables, just wondering if there's any scope to shorten or skip the Phase II work around Q6M combos and accelerate Phase III such that launches are ahead of, I guess, a 2030/'31 timeline. Thank you.

Luke Miels: Sure, Sachin. I think you get a pass on two questions. I don't think you asked a question last time. So, Deborah, super quick on acceleration options and then Tony on camli, please.

Deborah Waterhouse: So Sachin, we are looking to accelerate through execution of delivery of our Q6M or twice yearly in treatment and in PrEP. The FDA will not allow us or anybody else actually to skip the Phase II parts of the development journey. We have to demonstrate the level of efficacy safety as well as the appropriate partner for our Q6M. So we'll go through the journey of development to demonstrate all of that, but we're in dialogue with the FDA and there's no way we can skip the Phase II.

Luke Miels: Thanks, Deborah, Tony.

Tony Wood: Yeah. Hi, Sachin. Look, as you'll appreciate only a small number of people inside GSK have seen the CALM-1 data and we'll update you all when the CALM-2 data is in-house. It's on track. We have ~~last~~ [corrected: first] patient, last visit has already occurred.* So we're very much on track for publication around the middle of the year, as I've indicated. And perhaps just a reminder for everyone here again, 15% to 20% reduction relative to placebo in Phase III at 24 weeks will be seen as significant, right?

Luke Miels: Thanks, Tony. Thanks, Sachin. Next question, please.

* During the 1Q call - Tony Wood said "Last Patient last visit has already occurred" for CALM-2. This is not correct. Last Patient **First** Visit has occurred. Last patient last visit is scheduled for early in 2H. Timing for the phase III read out for CALM-2 remains on track early in 2H.

**Matthew Weston (UBS):** Thanks for taking my question. It's actually a follow-on to Sachin's secret second question. Deborah, in your opening comments, you expect confidence in the long-acting six months treatment regime on the market by the end of the decade. But given that we haven't yet achieved six months IM dosing for VH184, I have to be honest and say we're struggling to get to that timeline. Sach asked if you could accelerate it, and you said no. So, can you walk through the steps for development that gives you the confidence in being there at the end of the decade?

Deborah Waterhouse: So, we've got a Phase 2 program, which has already started for VH184, because I think what people sometimes think is when we present the data at CROI, that's where we are in the process. We've already started the Phase 2a, which is the oral step we need to go through with VH184.

We're expecting the VH499 Phase 2 to start in the second half of the year. And then basically we would be starting the Phase 3, which we are in dialogue with regulators over, as well as our full Phase 2 program in 2028. And that allows us then to generate the data that will give us an end of decade launch. So that's how everything's set out at the moment.

Obviously, you talk to the regulators every step of the way, as you design your clinical trials, you agree the end points, and then you move on to the next stage. So as we stand here today, the dialogue that we have had with the regulators, the Phase 2 program that we are in the process of agreeing and our proposed Phase 3 would lead us to an end of 2030 approval.

Luke Miels: Thanks, Matthew. Thanks, Deborah. Next question.

**Peter Verdult (BNP Paribas)**: Just one question, just to follow up on bepi ahead of EASL. In fact, there's a massive disconnect between your ambitions in terms of commercial ambitions for the product, and I think consensus, which has only had a couple of £100 million baked in.

I realize we cannot go into any B-Well details, but I would like to understand how GSK thinks about getting surface antigen testing part and parcel of standard practice. KOL feedback tells us this is really done presently. And then in terms of the checks that we've done with the community, they seem to be pointing to a sort of functional cure rate near 25% for the enthusiasm across the community to be really high. I know it could be statistic anywhere between 15% to 20%, but anything you're willing to say on testing and what is clinically meaningful from the docs you speak to as we await the EASL data?

Luke Miels: Sure. No worries, Peter. I think very fair questions. I mean, structurally, we've seen this in multiple disease areas. If there's no solution, there's no point looking for the problem. So many of these patients, if you look at the U.S. diagnosis rates, a prevalence of 1.2, I said before, only 500,000 are diagnosed in Europe to a similar ratio.

Japan's probably the best of all of them, but our expectation is and the feedback that we've got is that once you've got the accessible treatment option, because the downstream consequences of this infection are deeply unpleasant for the individual and the healthcare system, we expect that testing to increase. Nina, I don't know if you wanted to add any of the work that you guys have done to assess this or any other insights.

Nina Mojas: Yes. And Peter, I'm not surprised. This is a new, in a way, new approach in treatment of hepatitis B. So, a lot of these things are obviously very known to us as barriers, like antigen surface testing, like diagnosis. And we are going into that very, with eyes wide open, aware of that. But what is very obvious is that there are reasons why people want to be treated. It's a reduction of hepatocellular carcinoma, first thing.

The other one, just stigma of hepatitis B. And that comes with available options for treatment that are lifelong. And patients or physicians are not very keen on lifelong treatment. That's a big, big motivator to change. Testing is available. It's just not used because it doesn't help with anything. It doesn't guide current treatment. It's not required for initiation of treatment. As soon as there are options that are requiring testing, we believe that is going to increase.

And just the last one, I think we need to, we just need to remind ourselves, reduction of DNA at the moment is the standard, which is followed in practice. For patients who have reduced DNA and who have also reduced antigen level expression, their risk of hepatocellular carcinoma is dropping by over 70%, close to 80%. So it's a very significant driver of medical value and benefit. And that's what we see in the initial conversations with the regulators. As you can see, we have SENKU designation in Japan. We have breakthrough designation in the U.S. It is very much recognized by the healthcare authorities.

We are going into this, into what is a new way of treating this disease. And I think you need to allow us also certain level of, well, uncertainty how this is, how quickly this is going to be realized, but definitely the value of the drug is very clearly recognized.

Tony Wood: And then just a reminder on functional cure rates, because as Nina mentioned, the current broadly used approach is nucleoside and nucleotide therapy, for which the combination of DNA and surface antigen reduction for functional cure is less than 2% for a lifelong therapy.

Luke Miels: And if you look at pegylated interferon, either as I mean, it's 12 months of treatment and blue light symptoms for between 2% to 4% resolution. In China, experts would state it's slightly higher, but heavy burden on the patient. So, as Nina said, we're being very thoughtful about this, and but there's a high commitment to this asset and I think we've got something that will get experts' attention at EASL. So, let's see. Next question, please.

James Gordon (Barclays): Thanks a lot for taking the question. The question was about Exdensur. So, the early launch progress, I know it's early, and whether you are seeing any switching from existing more frequent IL-5s. I know there's the NIMBLE Exdensur switch trial that showed Exdensur was inferior to Nucala.

So, does that mean it's harder to get switches or are you still seeing some people do a switch? And just what do you think this launch will look like once you get the J-code? I can see how that could hold it back a bit but then once you've got the J-code, would it still be quite slow and steady because you're only then really going for the incident, not like the people already on biologics, if you're not switching.

And if I could squeeze in a follow-up, because a few other people did. Just on camlipixant, and I heard the comment on 15% to 20% benefit or Phase III being significant, but I think the Phase II was about twice as good as that. So, why would it be so much slower? And isn't a 15% to 20% pretty similar to what Merck had with their P2F3, but ultimately, I know there's some differences, but ultimately that wasn't approved by the FDA with about a 15% to 20% benefit.

Luke Miels: Sure. So, James, I'll ask the second question super quickly. So, I think the key thing is duration of effect and also the placebo adjusted, that's the operative term. And the element with Merck's product really was the off-target effect. In fact, it's a much more promiscuously binding molecule in terms of addressing the receptors of P3X3, which are present in the taste buds. And so, you get this taste dysgeusia which unblinded the product and also limited their dose selection. So, you had higher disturbance, toxicity, and lower efficacy, plus some regulatory issues around cough monitoring. So, I think we're talking apples and pears there, but we've taken those lessons and integrated them into not only the assessment, the clinical program, and we're looking forward to getting those results.

Tony, do you want to go through NIMBLE? Nina, then go through where we are commercially with the launch, and then I'm happy to add anything else.

Tony Wood: Yeah. Let me just, first of all, a little bit about NIMBLE and its design. It was a non-registrational study, so not a filing requirement. And what's important to understand about the population in NIMBLE is they were very well controlled. So, the general exacerbation rate was low.

It was not designed to make comparisons across switch in the various arms. In fact, if I allow that comparison to be made, the absolute, sorry, the difference in exacerbation rates was 0.08 per year. If that implies that a patient on therapy would need 12.5 years to realize a single additional exacerbation.

You put that into the context of the benefit for compliance that's associated with the longer acting agent as Nina answered earlier. I think you have the importance of depemokimab as a long acting agent in that population. I won't go any further on that, but the study was not designed to draw the conclusion that you have, James.

Nina Mojas: Yes, just to add. So at the moment, the number of patients that are initiating actually about 70% of them are coming from other biologics. In terms of the question, and obviously we would want majority of the patients to be bio-naive.

Just your question about, are we looking at just the incidence? Remember, only about 30% of patients are on a biologic. There is actually way more patients who are bio-naive than those who are bio-exposed. So there is significant pool of patients who are available.

In terms of access and J-code, so this is a therapy area where J-code is very relevant. It is going to unlock vast majority of the market at the moment, only about 20% of the commercial patients in the U.S. have access. And this is very normal in this therapy area. J-code is really a significant barrier initially, and then it opens the opportunity as the J-code becomes available.

Luke Miels: Yeah. And James, I'll just add some other market research, which I think is quite encouraging. So if you look at who's prescribing at this point, about 57% of the patients prescribed by pulmonologists, about 23% by allergists, which is in line with what we expected. Unaided awareness is ahead of benchmarks, and intent to use is nicely at benchmark. And the main driver is questions around access, which is what we expect, particularly when you're buying a six-monthly treatment. So we've got that approach, but obviously the ungating factor is the J-code. And actually, if you look at the T2, faith and belief in terms of sustained suppression of the key T2 drivers, this is beyond other biologics at this point.

So, we're quietly assembling the pieces which will drive usage of this product, but very similar to Blenrep, I think we need to wait until we're into the second quarter before we can give you the full picture. Also, we've just started launch in Japan. I was there the other day, very good traction. And Germany was also there the other day, and they've got good traction and good start already. So, I would say we just need to keep watching this space and stay focused.

**Sarita Kapila (Morgan Stanley):** Hey, thanks for taking my question. Recently, there was a change to the Florida ADAP, so Biktarvy access was removed and Descovy was restricted. So how should we think about this change and the broader signals for HIV reimbursement in the US? Is there any risk that we see similar changes elsewhere? Thank you.

Deborah Waterhouse: Yes, so thanks for the question, Sarita. So ADAP is the safety net program for people who are living with HIV who do not have insurance. And because states are strapped for cash, they are looking at ways to save money on ADAP. And what Florida did was two things. They reduced the threshold by which you were able to access ADAP and they restricted Biktarvy and Descovy.

There was a court case brought immediately by community around the threshold at which you can enter ADAP and they won. So it went back to being 400% of the poverty threshold versus 150. So that was reversed. But there is the opportunity and there always has been actually to sort of tighten the formulary. And that is currently taking place in Florida. And we've seen people switching off Descovy and Biktarvy onto other medicines, obviously Dovato and Cabenuva as well.

So I think this is an area of focus as it has been for a while. I think the court case that was brought immediately by the community was very helpful because the threshold of when you can benefit from ADAP was not successfully reduced. But I think we should expect other states to look at ADAP and to make sure that it's being run efficiently and effectively.

But overall, I don't think you're going to see a reduction. I think what you might see is some changes to formulary. But as we know, it's a very guideline driven therapy area. The community are now pushing back at the restriction of Descovy and Biktarvy. So that may in its own right end up being reversed. But at the moment that is still in place.

**Michael Leuchten (Jefferies)**: Thank you. If I could please just go back to the Q2 business update, just trying to understand, is this meant to be a comprehensive review, both top line and bottom line trajectory, or is it meant to be a portfolio update around the pipeline, including ViiV, please?

Luke Miels: Thanks, Michael. The latter. I mean, we've found in the past we do meet the management events as standalone. They're useful to get granularity, but the portfolio is becoming broad enough and complex enough. We thought it would be helpful for you and shareholders for us to step you through why we're so enthusiastic. And what we've been doing with our time over the last few months in terms of accelerating these assets. So that's the intent, and to give, yeah, just greater granularity, more depth on the data. Thanks, Michael.

**Simon Baker (Redburn):** Thanks so much for taking my question. A slightly broader one, just going back to one of your opening comments, Luke. You talked about accelerating pipeline delivery. I wonder if you could just sort of dig down and give us a little bit more colour on that. Is that about changing decision-making processes now, or is it about changing development practice and trial design going forward? So just some colour on what that phrase means in reality would be great. Thank you.

Luke Miels: Yeah, sure, Simon. And I always make damn sure I attach any statement to something that we are actually doing in practice, so be sure of that. What does that look like? So every two weeks, Tony, Nina, and myself, Mondher, and Deborah, if it is HIV, with David, we look through all the clinical execution, look at what studies are on track, which are not, and then it may trigger a discussion around the protocol design, the execution on the ground.

The meeting then may pivot to some lifecycle opportunities that we have got, if Julie has found some money under the bed, that we can accelerate those programs and the economic justification and the clinical justification for doing that. So, very dynamically managing the portfolio, but again, we are not sort of writing emails to each other and 10 layers of management.

It's us interacting directly with the team leaders who are managing those programs and looking them in the eyes, and they get to look us in the eyes about where the program is at, what is going right, what is not going right, and how do we fix it? Or if there is an opportunity, how do we exploit that without having to sort of have endless meetings to discuss that?

So, out of that, we are creating a more aggressive culture in terms of pursuing opportunities, but also one that people have to back up in what they are doing with the facts, or at least a logical explanation,

scientifically, clinically, why that may be a good decision to make. And then we want to gauge the level of risk we are taking.

So it's really everything that you are saying, that the core focus is, I strongly, and you guys know this better than me. I strongly believe the way that we are going to create value is to accelerate what we have in the late-stage portfolio and get it to patients faster in a more broad fashion. There are opportunities for lifecycle management, and then translate that into faster top-line growth and commercial success. So, and if we do that, we should be creating value for our shareholders. So that's how it works.

We also have other ways, again, to redirect resources. And if we see something not working, we either fix it or take the resources away and give them to someone else. So it is a Darwinian process and it is designed to transparently create value. I hope that helps.

**Steve Scala (TD Cowen):** Thank you so much. A question on Shingrix with three brief parts. First, can you quantify the magnitude of U.S. inventory stocking? Second, are things improving in China? And thirdly, it seems like you're all in on dementia starting a 34,000 patient trial after being cautious for a long time. Is that how to read it? Thank you.

Luke Miels: Right. Thanks, Steve. So I'll answer the inventory one pretty quickly. And then maybe, Nina, if you wanted to cover China. I mean, if you look at the U.S., the IZ rate now is around 45%. So that's up three and a half points versus same time last year, which is in the range that we gave you of two to four patient points each year.

If you look at the remaining epi, there's about 70 million, people above 50 million, who remain unvaccinated. About a third of them have intent to get vaccinated that's material based on the market research. But again, we're concentrating on the comorbid population that are more motivated and their doctors and pharmacists are more motivated to do that.

All the market research on pharmacists and doctors is stable. In Q1, actually, Shingrix was the number one priority for pharmacists to vaccinate, which is the same as last year. We get to the flu season. In terms of stocking, we did launch the PFS, the fully liquid, in '26. It's easier for pharmacists. We don't factor any demand increase because of that. But it's just easier for the pharmacists to employ it.

The wholesalers were pretty steady. So Q126, 0.6 million doses. You look at the end of last year, it was 0.5. If you look at same time last year, it was 0.4. So very much in the typical range. There is some increase in

retail inventory. So that's associated with the PFS. So it was 2.4. If you look at same time last year, it was 1.7 million doses at the end of 2025, which is not necessarily a fair comparator of the flu season, 1.4. So, stocking has a component there, but we're also seeing, reasonable underlying demand following the strategy of focusing on comorbid.

And Nina, anything you wanted to add on U.S. or China, and then we'll go to Tony.

Nina Mojas: Yeah. So just briefly on China, the number of doses administered to patients is increasing. So that demand is improving. You will not see that in the sales numbers because that's going out from the available stock at Zhifei. Probably for this year, at least majority of this year, we would not see sales numbers changing on the GSK side as that stock is being reduced.

Luke Miels: Thanks, Nina. So a work in progress very much in China. Tony?

Tony Wood: Yeah, Steve. On Fin dementia, I would say this is just the latest in the plan we described. It sits alongside those studies that we have running in the UK and now a pragmatic study in Finland. To give you some details, this is dementia diagnosis. And as you said, around 30,000 individuals. It's a Shingrix versus placebo study, and the data capture is largely passed through a registry basis. It's on a three-year follow-up, but I would look at it very much as just the next example in what will become a collection of studies that explore outcomes with Shingrix in both dementia and indeed MACE outcomes that I'm doing in partnership with Mondher and the MedAffairs team.

Luke Miels: Yeah. I would stress that MACE component, Steve. Great. Thanks for your question. Next question, please.

**Emmanuel Papadakis (Deutsche):** Thank you, sir. Yeah. I'm tempted to ask Julie about the money under the bed, but I'll take one on Jemperli. Maybe you could talk a little bit about the softer Q1 relative to expectations after a pretty strong run of results. I'm particularly interested in how endometrial and rectal outlook is shaping up.

I mean, you do have AZUR 1 and 2 pending, but they're in the MSI high setting, and you already have a tumor agnostic MSI high label. So I would imagine they're going to have pretty limited impact. Is it going to be JADE in head and neck that really catalyse the next step up? And what's the sort of quantum of commercial opportunity there? Thank you.

Luke Miels: Great. Thanks, Emmanuel. Nina, you want to cover?

Nina Mojas: Yeah. I think we have talked about this before. Of the 2 billion that we have communicated externally for Jemperli --- endometrial cancer is about 1. And then colorectal and head and neck we see as another 1 billion. And at the moment, we are on track for that. AZUR 1 is going to read out later this year. Very high belief and confidence that that's a positive study as we have seen already. So, and then AZUR 2 obviously significantly higher opportunity and head and neck definitely.

Luke Miels: Yeah. And Emmanuel, we've still got a lot to do operationally in the U.S. in terms of endometrial. You look at the stats, about 60% of oncologists just used Keytruda despite the overall survival. So, we've got plenty of area to target those individuals. And we do have the market research that if a physician can recite the survival benefit, they're a lot more likely, obviously, to use Jemperli. So again, we remain very committed to this product and look forward to updating you as we get those readouts.

Tony Wood: Just to complete the picture as well, we have the chemo-free study and EC which will update this year as well. That's looking to expand the population there too.

**Seamus Fernandez (Guggenheim):** Hi, everybody. Thanks for the question. So, just quickly wanted to get a sense on Nucala and the uptake there. Where are you seeing the emergence of sort of broader utilization. And how do you feel that actually positions Exdensur over time in that opportunity? Thanks so much.

Luke Miels: No worries. Thanks, Seamus. So if you look at the growth of Nucala in the U.S., about 50% of that volume is from COPD. Globally, it is about a third. And then you have got EGPA, HES, and other indications for Nucala more broadly.

But as we launch Exdensur, we take the resources off Nucala, excluding COPD. So we have a team in the U.S. who is still promoting COPD and doing quite well, as you can see. But all of the other indications are no longer promoted.

We are 100% committed to Exdensur, and that is the strategy. And I will just come back to the relative volatility of these patient populations, which I think surprises everyone and creates a degree of churn that we are looking to exploit with Exdensur.

So, great. I will stop there. Hopefully I answered your question, Seamus. If I didn't, I am happy to follow up offline. Thanks, everyone. Appreciate your interest in the company and hope the questions and answer session was useful. Thank you.